PhysicianPerformance
Empowering Physicians. Elevating Healthcare.

Provider Change/Term Form

Group Name:	TIN:
Provider Name:	Provider NPI:

Effective date of the **change/term** (*final effective date at health plan is dependent on contractual obligations):

Type Of Change

Phone Number Change
Old phone number to be removed _____
Old fax number to be removed _____
☐ Primary phone number
☐ Primary fax number
☐ Secondary phone number
☐ Secondary fax number
New phone number to add _____
New fax number to add_____

☐ **Provider name change**
New First Name:
New Last Name:

Change Panel Status
☐ Patient panel change-Open
☐ Patient panel change-Close

*Please be aware all panels will be open or closed with all contracted payers

Designation change (*New Designation)
☐ Primary Care Physician (PCP)
☐ Primary Care Physician / Specialists (PCP/Specialist)
☐ Specialist (SCP)
* Add description

Scope of service change:
Description of services being added or removed from the practice:

Add or Remove location

Add Location	Remove Location
Address Type: ☐ Primary ☐Secondary ☐ Billing ☐ Mailing	Address Type: ☐ Primary ☐Secondary ☐ Billing ☐ Mailing
Address line 1:	Address line1:
Address line 2:	Address line 2:
City: State:	City: State:
Phone: Phone:	State: Fax:

***If you have additional addresses to add or remove, please attach them to a separate sheet**

TIN Change

New TIN information:	**Old** TIN information:
Legal Name:_____	Legal Name:_____
TIN #_____	TIN # _____

Group (Type II) NPI Change

New NPI information:	**Old** NPI information:
NPI number _____	NPI Number_____

Provider Termination

Which provider in the practice will take over the patient panels of the terminated provider (PCPs only):

_____

Reason for termination (please check only one box):

☐ Resigned
☐ Leave of absence*
☐ Retired
☐ Deceased
☐ Provider sanctioned*
☐ Sabbatical*
☐ Moved out of state
☐ Other

**Please provide a short explanation of the details for termination(e.g. duration of leave, why sanctioned, sabbatical specifics)*

_____
_____

Contact Person Submitting/Authorized Representative for TIN

Name:	Signature:
Phone:	
Title:	Date of submission:
Email:	

Please send to: PLLCAdministration@bidmc.harvard.edu